RURAL HEALTH

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY1999 Performance Report

The charge to the Office of Rural Health Policy from Congress in 1987 was to serve as a proponent for rural interests in the Department's health care policy process. The office has a specific mandate to review HCFA proposals and regulations, to maintain an information clearing house, and to provide information on rural health activities in other federal agencies.

The Office of Rural Health Policy is the only office in the Department solely concerned with rural health care needs. It is active in coordinating rural health care programs and policies within HRSA, with HCFA, and with many federal agencies such as USDA. Because the challenges to providing adequate care in rural communities are manifestations of many structural issues in the national health care 'system,' the office has become strategically involved in efforts, large and small, to bring about national reforms.

The office engages in a wide spectrum of activity, from research and policy development to constituency-building, to demonstration grants for new rural service delivery systems. The Office administers five grant programs and provides grantees and contractors with technical assistance through workshops, phone conferences, site visits, and other efforts. To cultivate local support for rural health issues, the office has promoted extensive networking among rural health interests within and among the States. This has resulted in a national information network. We support State and regional conferences and lend financial and technical support for new rural health initiatives.

The Rural Health Program includes four components:

2.26: Rural Health Outreach Grants

2.27:Rural Health Policy Development

2.28: Rural Hospital Flexibility Grants

2.29: State Offices of Rural Health

2.26 Program Title: Rural Health Outreach Grants

Performance Goals	Targets	Actual Performance	Reference
I. Eliminate Barriers to Care **A. Increase Utilization for Underserved Populations** 1. Outreach Program: Develop and operate collaborative models of health care services in rural areas which will serve underserved populations.	FY01: 854,000* FY00: 764,000 FY99: 680,000 FY98: 616,000 ***numbers represent number of persons served per year	FY 01: FY 00: FY 99: (9/00) FY 98: 630,000	B232
IV. IMPROVED PUBLIC HEALTH AND HEALTH CARE SYSTEMS **C. Promote Systems and Infrastructure Development** 1. Rural Network Development Program: Improve rural health care access by developing vertically integrated provider networks that involve rural health providers.	FY 01: 270 providers* FY 00: 270 FY 99: 270 ***represents number of providers in networks	FY 01: FY 00: FY 99: (9/00)	B232
Total Funding: Rural Health Outreach Grants ($ in 000's)	FY 2001: $38,892 FY 2000: $35,880 FY 1999: $30,401 FY 1998: $22,863	B x: page # budget HP: Healthy People Goal	

2.26.1. Program Description, Context and Summary of Performance

Rural Health Outreach Grant Program: Rural Health Outreach grants are providing essential health care services to hundreds of thousands of Americans living in rural areas of the country. The goals of the program are to improve access to care in underserved rural areas through the development of new

health care delivery systems that create and sustain greater collaboration among providers. The grants require health care organizations and the communities they serve to develop a implement a consortium with at least three different providers to strengthen existing health care services or bring new services to the community. Services supported by the grants include primary care, mental health, dental care, health education and promotion, health related transportation, mental health, specialty care, school-based clinics and others. Grantees include rural hospitals, clinics, public health agencies, charitable organizations, educational institutions and other non-profit organizations located in rural areas of the country. Target populations include rural minorities, the elderly, pregnant women, children and adolescents, and rural Americans with special needs. The average grant serves over 7000 persons each year. Close to 2.5 million rural Americans have been served by the program since its inception in FY 1991. Over 60 percent of the grantees report a continuation of their activities after federal support is terminated. Grants are for three years. Awards have been made in 46 States and 4 Territories.

Rural Network Development Grants: These grants are designed to support the development of vertically integrated provider networks in rural communities. Rural health care providers are finding that they cannot survive in today's health care market without forming alliances with other providers. This program is founded on the belief that locally owned networks of rural providers can improve access to care in rural communities, better coordinate local health care services, and help rural communities respond to the growing presence of managed care. Local ownership and control is more responsive to community needs and more likely to result in systems that will last over time. The typical grant might involve a hospital, local physicians, and long-term care providers. Under this program, the focus is on developing the organizational structure and capabilities of rural networks as opposed to the actual delivery of services. All grantees participate in an evaluation activity that will help us understand more about the development and operation of provider networks in rural areas.

2.26.2. Goal-by-Goal Presentation of Performance

Goal I.A.1: Outreach Program: Develop and operate collaborative models of health services in rural areas which will serve underserved persons.

Every Outreach Grant is different. Each has different objectives, different providers, and different target populations. Data from the Outreach Grantees is submitted annually through the grant renewal process and through a special report that grantees are asked to submit in their third and final year. Since every project is different, it has been difficult to aggregate the data.

The data submitted by grantees does provide a rough estimate of the numbers of people served by the grant. The number can be quite large in the case of projects that involve the use of media presentations or distance learning technologies. On the other hand, some projects are providing very specialized

services to a small population (e.g. pregnant women in a community). We are working to design a reporting system that will give us more accurate and reliable data on the numbers of people served by different types of projects and other measures for evaluating the program. This system will be in place by the time new awards are made in FY 2000.

Goal IV.C.1: Rural Network Development Program: Improve rural health care access by developing vertically integrated provider networks that involve rural health providers.

In addition to reports received through the normal grants process, the program relies on the Rural Network Development Grant Reporting System. This system provides information on the characteristics of the networks; their organizational capabilities; activities they have taken to strengthen and expand the networks; barriers to network formation in rural areas, and other information. Baseline information on the status of grantee networks was collected in 1998. The second reports from grantees were submitted earlier this year and are under review. An analysis of these reports will be available by early 2000.

Every network is different, so it is difficult to quantify specific results across all grantees. For example, some networks formed in the hope of developing a local managed care product, while others have formed to integrate administrative functions such as billing, purchasing, etc. However, the lessons learned from the experience of these grantees will be quite valuable to other providers seeking to become a part of larger networks in rural areas.

2.27 Program Title: Rural Health Policy Development

Performance Goals	Targets	Actual Performance	Reference
IV: IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **A. Improve Information Development and Dissemination.** 1. Develop policy relevant research addressing racial disparities and the rural elderly.	FY 01: N/A FY 00: N/A FY 99: 5	FY 00: FY 99: 1 paper on racial disparities completed, 5 on rural elderly underway.	B230
2. Rural Health Policy Development: Conduct and disseminate policy relevant research on rural health issues. (For FY 2000 and 2001, we are focusing on the total set of studies) .	FY 01: 18 research papers FY 00: 25 research papers (5 research studies on the 1997 BBA)	FY 01: FY 00: FY 99: 3 research studies on BBA underway, 5 new BBA studies to be funded	B230
Total Funding: Rural Health Policy Development ($ in 000's)	FY 2001: $6,101 FY 2000: $12,679 FY 1999: $6,583 FY 1998: $5,386	Bx: page # budget HP: Healthy People Goal	

2.27.1 Program Description, Context and Summary of Performance

This activity supports the policy development functions of the Office of Rural Health Policy. These functions are designed to help policy makers, both in Washington and throughout the nation, better understand the problems that rural communities face in assuring access to health care for their citizens.

Part of this activity, the Rural Health Research Center Program, is the only health services research

program dedicated entirely to producing policy relevant research on health care in rural areas. There are currently five research centers at different locations throughout the country. Each Center has developed its own areas of expertise. One Center is studying the effects of managed care in rural communities, access to managed care by rural Medicare beneficiaries, quality of care issues, and the development of provider networks in rural areas. Another Center is studying the availability of long-term care services in rural areas. A third Center is examining the effects of changes in Medicare payment systems on rural providers, with special emphasis on changes brought about by the Balanced Budget Act of 1997. The other Centers are focusing on rural health care workforce issues and the geography of health care. The work of the Centers is published in academic journals and other venues. The work is widely disseminated by the Rural Information Center (see below) and the State Offices of Rural Health. The emphasis is on studies that will have a timely impact on policy decisions at federal and state levels. For example, one of the Centers produced a paper this year which described the potential impact of Medicare's new prospective payment system for hospitals on small hospitals in rural communities. That study has had a major impact on policy debates related to the new payment system.

In FY 2000, grants to current Research Centers will be ended and new awards will be made to six centers for FY 2001-03. Specific research topics will not be selected until then. Twenty-four projects will be funded with 18 completed in FY 2001, due to multi-year projects.

In addition to the Research Centers, this activity would continue support for: (1) the National Advisory Committee on Rural Health which advises the Secretary on rural health programs and policies; (2) dissemination of rural health information by the Rural Information Center (the Center responds to thousands of inquiries each month and disseminates information through its web site); and (3) small projects that assist the Office of Rural Health Policy and the Health Resources and Services Administration in identifying and clarifying rural health care issues.

2.27.2. Goal-by-Goal Presentation of Performance

Goal IV. A. 1: Develop policy relevant research addressing racial disparities and the rural elderly.

Performance:

Last year we established a performance goal for this program based on the number of papers developed by the Centers specifically addressing issues of racial health disparities among rural minority populations and issues on the rural elderly. It was our intention to make this a priority area for rural health research. In pursuing the area of disparities among minority populations, the Centers have been hampered by a lack of data on rural minorities. Existing national surveys are not particularly helpful for rural minorities and there has been very little effort to collect information by other means. As

a result, very little research has been done specific to rural minorities. Consequently, only one research paper on rural minority health has been published by the Centers in FY 1999. There are 5 studies on the rural elderly either completed or nearing completion, including a focus on long-term care situations and care of patients with Alzheimers disease.

Goal IV.A.2: Conduct and disseminate policy relevant research on rural health issues.

Performance:

For FY 2001, we are rephrasing the performance goal for the Research Center Grants to focus on the total number of research papers produced by the Centers each year. We think this is a much better measure of overall productivity under the program. The target for FY 2001 is 18 research/analytic papers. Another 6 projects will be funded, but due to their multi-year nature, will not be available until FY 2002.

Within the target, there is an emphasis on policy research concerning the impact of changes in Medicare payment policy legislated by the Balanced Budget Act (BBA) of 1997 and the Balanced Budget Refinement Act of 1999. These changes, which include prospective payment systems (PPS) for outpatient, home health, and skilled nursing facilities, are expected to negatively impact the financial health of rural hospitals. Rural hospitals that operate home health agencies and skilled nursing facilities may be especially vulnerable to these financial reforms. Previous Medicare reforms, such as inpatient PPS, have had large, unanticipated negative impacts on rural hospitals. Legislative reforms, including special payment categories, were enacted to lessen the negative impact on rural areas. Through the policy research on the 1997 BBA, we expect to identify hospitals and rural communities that may be adversely impacted by the new PPS. The research will help not only to predict the impact of the payment reforms on rural hospitals but also to identify options for changes in the new PPS to lessen the negative effects on rural hospitals, their patients, and their communities. Several research studies will focus on the impact of each new PPS individually (for example, the impact of Medicare payment reform on home health care in rural areas). Other studies address the interaction of these PPS changes to examine the total impact on rural hospitals (for example, implications of Medicare payment changes on the viability of rural hospitals). Three research studies on the 1997 BBA were conducted in FY 1999, and five are planned for FY 2000.

2.28 Program Title: Rural Hospital Flexibility Grants

Performance Goals	Targets	Actual Performance	Reference
IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS: **C. Promote Systems and Infrastructure Development** 1. 100% of eligible states will be participating in the Rural Hospital Flexibility Program.	FY 01: 100% FY 00: 100% FY 99: 90%	FY 01: FY 00: FY 99: 90% (43 of 48 eligible States)	B235
Total Funding: Rural Hospital Flexibility Grants ($ in 000's)	FY 2001: $25,000 FY 2000: $25,000 FY 1999: $24,992 FY 1998: NA	B x: page # budget HP: Healthy People Goal	

2.28.1 Program Description, Context and Summary of Performance

The Rural Hospital Flexibility Grant Program was authorized in the Balanced Budget Act of 1997. The first appropriation for the program was in FY99. The program provides grants to States to help them improve access to essential health care services in rural communities. Grants are awarded to States to: (1) develop and implement a state rural health plan; (2) designate Critical Access Hospitals that will be eligible for cost-based payments through the Medicare Program; (3) assist these Critical Access Hospitals and the communities they serve in developing networks of care; and (4) improve rural emergency services by integrating them with other services in selected rural communities. The program provides support for local citizens, employers, health care providers and other groups to conduct the community-based activities that are necessary to save at-risk rural hospitals and to design better systems to meet local needs. For hospitals and other providers, the program will provide technical assistance and support to: (a) develop integrated networks of care; (b) examine and implement the conversion process for hospitals that wish to be designated as Critical Access Hospitals; and improve information systems, quality assurance programs, and other activities.

2.28.2. Goal-by-Goal Presentation of Performance

Goal IV.C.1: 100% of eligible States will be participating in the Rural Hospital Flexibility Program.

Performance:

The first grants to states under this program were awarded in August-September, 1999. Some 43 of 48 eligible States are participating in the program and received a grant for FY 1999. A few States have deferred the decision and will apply for a grant in Fiscal Year 2000.

At about the same time we hope to have in place a technical assistance contractor to work with the states on program implementation and an evaluation program. These two activities will produce information on grant supported activities in the states. The program will be identifying more specifically what is measurable, such as the number of hospital conversions that take place, the types of networks that are developed as part of the conversion process, new strategies for linking emergency services to the Critical Access Hospitals, and other outcomes of the program. Based on that identification, performance measures will be strengthened. We will also have information on how well we are responding to the states in terms of their needs for technical assistance.

2.29 Program Title: State Offices of Rural Health

Performance Goals	Targets	Actual Performance	Reference
I. Eliminate **Barriers to Care** **A. Increase Utilization for Underserved Populations** 1. State Offices of Rural Health: All States will have implemented performance outcome measurement indicators and reported a summary of their outcomes.	FY 01: 50 States FY 00: 32 FY 99: 19	FY 01: FY 00: FY 99: (6/00)	B236
Total Funding: State Offices of Rural Health ($ in 000's)	FY 2001: $3,000 FY 2000: $3,000 FY 1999: $2,999 FY 1998: $2,986	B x: page # budget HP: Healthy People Goal	

2.29.1 Program Description, Context and Summary of Performance

The State Offices of Rural Health (SORH) program of matching grants supports states to: (1) collect and disseminate information on rural health in their states; (2) coordinate rural health resources and activities statewide; (3) provide technical and other assistance to rural providers and communities; and (4) help communities recruit and retain health professionals. This innovative Federal and State partnership reaches out to provide rural communities with the tools they need to address their health care problems. The State Offices are now playing a major role in implementing the Medicare Rural Hospital Flexibility Program authorized by the Balanced Budget Act of 1997. Most of them will be managing the grants that are being awarded to States for this new program.

2.29.2 Goal-by-Goal Presentation of Performance

Goal I.A.1: All States will have implemented performance outcome measurement indicators and reported a summary of their outcomes.

Performance:

By the end of calendar year 2000, 32 State Offices of Rural Health will have implemented performance outcome measurement indicators. For FY 2001, all 50 will have implemented such a process and will have reported a summary of their outcomes. A report is currently under development on what happened in FY 1999 and is expected to be available in June, 2000.